STATEMENT FOR FREEDOM OF CHOICE

State Form 46016 (R4 / 7-99) / HCBS 0003

☐ Aged and Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver.

SECTION I: CHOICE BETWEEN INSTITUTIONAL PLACEMENT AND HCBS WAIVER SERVICES

NOTE: This section should only be completed for individuals that are choosing institutional placement. Those recipients that are choosing waiver services will sign the Freedom of Choice statement on the HCBS Plan of Care / Cost Comparison Budget form.

SERVICES AVAILABLE

☐ **NF / I** ☐ **NF / S** ☐ **Hospital** ☐ **ICF / MR** ☐ **NF/TBI**

I have been fully informed of the services available to me in an institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care.

I understand that in order to be eligible for Medicaid Waiver Services, the costs of waiver services may not exceed the costs of institutional care.

As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.

CHOICE OF SERVICE

☐ At this time, I have chosen to receive waiver services in home and community-based settings; rather than in an institutional setting.

☐ At this time, I have chosen to receive services in an institutional setting, rather than waiver services in home and community-based settings.

SIGNATURES

Signature of recipient	Date signed *(month, day, year)*
Signature of: *(check one)* ☐ Family ☐ Guardian ☐ Witness	Date signed *(month, day, year)*
Signature of Case Manager	Date signed *(month, day, year)*

SECTION II: CHOICE BETWEEN HCBS WAIVER SERVICES AND MEDICAID MANAGED CARE

NOTE: This section should only be completed if a "Targeted" HCBS waiver applicant is currently on a Medicaid Managed Care program or if an HCBS waiver recipient wants transfer to a Medicaid Managed Care program (if eligible). An individual can not be on a HCBS waiver program and a Medicaid Managed Care program.

CHOICE OF PROGRAM

(To be completed after all eligibility determinations have been made.)

I have been fully informed of the array of services available under the HCBS Waiver program and the Medicaid Managed Care program.

☐ At this time, I have chosen to receive HCBS Waiver services, rather than Medicaid Managed Care services.

☐ At this time, I have chosen to receive Medicaid Managed Care services, rather than HCBS Waiver services.

SIGNATURES

Signature of recipient	Date signed *(month, day, year)*
Signature of: *(check one)* ☐ Family ☐ Guardian ☐ Witness	Date signed *(month, day, year)*
Signature of Case Manager	Date signed *(month, day, year)*

DISTRIBUTION: ☐ **Original** - Waiver Case File; ☐ **Copy** - Recipient; ☐ **Copy** - AAA Case File; ☐ **Copy** - BDDS Case File *(Autism, ICF/MR only)*